

**California CAGB Outcomes Reporting Program (CCORP)  
Clinical Advisory Panel  
Minutes of October 15, 2013**

The meeting was held at The Office of Statewide Health Planning and Development, 400 R Street, Sacramento, CA 95811

**Clinical Advisory Panel Members present:**

Ralph Brindis, M.D., FACC	James MacMillan, M.D.
Andrew Bindman, M.D.	Rita Redberg, M.D.
Gordon L. Fung, M.D., MPH, Ph.D.	Richard Shemin, M.D.
Hon S. Lee, M.D.	J. Nilas Young, M.D.

**Clinical Advisory Panel Members absent:**

Cheryl Damberg, Ph.D.	
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**OSHPD Staff and Consultants present:**

Robert David, OSHPD Director	Ron Spingarn, Deputy Director, OSHPD HID
Joseph Parker, Ph.D., Healthcare Outcomes Center	Beth Herse, Senior Staff Counsel
Holly Hoegh, Ph.D., HOC	Merry Holliday-Hanson, Ph.D., HOC
Zhongmin Li, Ph.D., UCD Contractor	Denise O'Neill, CCORP Data Manager, HOC
Robert Springborn, Ph.D., HOC	Lisa Cook, Contracts Manager, HOC
Dominique Ritley, MPH, UCD Contractor	Sarah Park, MPH, HOC
Geeta Mahendra, MA, UCD Contractor	TaNisha Roby, MPH, HOC
Niya Fong, HOC	Jason Brandes, HOC
Limin Wang, HOC	Alysha Lal, HOC
Anthony Steimle, M.D., Consultant	

**Others present:**

Joseph Carey, M.D., UCI Medical Center, CASTS	Stephen Rossiter, M.D., Mercy General Hospital
William Bommer, M.D.	Junaid Khan, M.D., CASTS
Audrey Fisher, MPH, Sutter-Palo Alto Medical Foundation	

**1. Call to Order Introductions**

Ralph Brindis, M.D., Chairperson, called the meeting to order at 9:09 a.m. A quorum was present to conduct business.

**2. Welcome and Introductions**

People in attendance introduced themselves.

**3. Swearing in of New Panel Members – Bob David, Director, OSHPD**

The five new Clinical Advisory Panel (CAP) members were sworn in by Director David. The new members signed their Oaths.

**4. Approval of Minutes of March 19, 2013 Meeting**

The minutes were approved unanimously.

**5. Director's Report – Robert David**

Director David reported that the Fiscal Year 2013-2014 budget was passed on time and that the state is emerging from the fiscal crises of the last few years. The furlough program has ended, and OSHPD is back to being fully staffed. Travel restrictions are not as severe as in years past.

The Affordable Care Act (ACA) emphasizes the need for access to primary care physicians and underserved communities. Continued interest remains in strengthening and funding of the department's workforce programs. Accordingly, the California Endowment has announced a \$52M investment in our workforce programs over the next three years. This will help to significantly strengthen loan repayments, as well as some of the residency programs funded through the Song-Brown Program.

The Director also reported that as a result of ACA, there is a dip in hospital projects for the first time. Hospitals are being very conservative in their spending while waiting out the impact of ACA. The department anticipates it will be several quarters before the true impact on hospital revenue streams can be analyzed.

The Director, in response to a question posed by Dr. Brindis, addressed his thoughts on the Figueroa Bill (SB680 2001 - the legislation establishing CCORP and the mandatory reporting of CABG outcomes) and the vision for the future and direction of the CAP. He stated that it is important to be able to provide consumers with actionable health data, especially with ACA and new patients accessing healthcare systems for the first time.

**5. Program Director's Report – Holly Hoegh, Ph.D.**

Dr. Hoegh identified the statutory duties of the panel to be exercised at this meeting: review and approve changes to CCORP data elements, approve the risk adjusted model for CABG + Valve, and approve the definition of Isolated CABG.

She presented slides that reported the volume of isolated CABG, Non-Isolated CABG, PCI and Valve Surgery over time. Isolated CABG volumes (which are publicly reported) have decreased by about 50% compared to when the program started 10 years ago; this trend appears to be leveling. Non-isolated CABG procedures have declined slightly but remained more stable. PCI climbed for a while but has started to decline. Valve-only surgery appears to be increasing. Overall mortality rates for Isolated CABG are down.

The 2011 hospital level report should be released in Spring 2014. Data for 2012 is in-house and an audit of 37 hospitals is underway. We've also begun 2013 data collection.

For 2014 data there are changes in definitions due to STS revisions, which will be effective July 1, 2014. In the past, STS revisions were made at the beginning of the calendar year, but STS changed to a mid-year schedule change starting in 2011. The challenge to OSHPD and the hospitals regarding the mid-year changes have been expressed to STS.

#### **6. CCORP Background – Joseph Parker, Ph.D.**

Dr. Parker explained that the reporting program started in 1995 as a joint collaboration between OSHPD and Pacific Business Group on Health (PBGH). He noted that both Dr. Steimle and Cheryl Damberg have been with the program since its inception. The initial idea of the program was to voluntarily report on risk-adjusted CABG mortality rates for hospitals.

In 2001, the Consumers Union sponsored legislation intended to make mandatory risk-adjusted reporting on mortality for hospital and surgeon. After the law was enacted, the first Panel meeting was held May 7, 2002. Currently, the law mandates that hospitals report annually and surgeons report every other year.

Outcomes have expanded beyond mortality to include risk-adjusted readmission rates and post-operative stroke rates. OSHPD is mandated to report on **all** CABG procedures, but currently they only report on isolated CABG procedures since an acceptable risk-adjustment model has not yet been developed for other types of CABG surgery.

Dr. Parker explained that the law states OSHPD should report mortality performance in five categories, but currently only reports three. There does not appear to be an acceptable method for creating a five category system of performance classification.

OSHPD collects and uses National STS data elements and a limited number of non-STS data elements, as prescribed by law.

Dr. Parker also went on to explain that hospital-observed outcome rates are risk-adjusted to recognize variation in severity of illness among hospital caseloads.

#### **7. Chairperson's Remarks – Ralph Brindis, M.D.**

Dr. Brindis acknowledged the partnership with the Healthcare Outcomes Center, CCORP, and working with Joseph Parker, Holly Hoegh and the Panel. He also recognized Joseph Carey, one of the quality cardiovascular surgery leaders in California.

Dr. Brindis provided some additional historical background relative to a concern presented by the American College of Cardiology when the Figueroa bill came out. Specifically, that there was no due process related to the ability of the physicians to interact with the data and offer feedback. The creation of the Clinical Advisory Panel was driven in part by this, and their input on CABG reporting of hospital and physician performance has had a significant impact.

A discussion ensued about the applicability of the Figueroa Bill (SB680) in today's healthcare climate. It was agreed that the current reports are relevant but other areas of opportunity to measure outcomes, both quality and

cost, as well as potential topics for the next CAP meeting can be vetted out later in the day during a “Blue Sky” discussion.

#### **8. Overview of the Bagley-Keene Open Meeting Act – Beth Herse, OSHPD Staff Attorney**

Ms. Herse provided an overview of the Bagley-Keene Open Meeting Act (BKOMA). The purpose of the Act is to assist – to aid in the conduct of the people’s business. She explained that the CAP is considered a State body created pursuant to statute and appointed by the Director. As a State body, the CAP must follow all of the BKOMA laws. All work of the Panel - discussion, deliberation and decision making must be done in an open and public way. All meetings must be open to the public.

Accordingly, the BKOMA specifically prohibits a majority of members from having contact to discuss or conduct the business of the CAP (whether all together or one at a time) outside of a meeting in order to discuss CAP business. However, it does not prohibit individual contact or conversation between a CAP member and a non-member.

She went on to explain that an agenda must be published at least 10 days before a meeting and all topics being transacted or discussed must be listed. This allows any member of the public to hear and participate in the process. No action may be taken on any item that was not published in the agenda. Any writings (this includes hardcopy or electronic) provided to the members of the CAP in connection with the matter that is subject to discussion or consideration, are considered public records.

Dr. Lee asked about an avenue for remote or virtual CAP meetings due in part because of the logistics of travel for those members who reside outside of Sacramento. Ms. Herse explained that the law does not prohibit this, but there must be a physical place for public access.

#### **9. Revisions to CCORP data elements submitted by Hospitals for July 1, 2014 – Holly Hoegh, Ph.D. and Zhongmin Li, Ph.D (action item)**

Dr. Hoegh discussed proposed changes to CCORP’s STS-related data elements that would become effective July 1, 2014. The proposed changes included ten data elements with revised definitions, four new data elements, and two dropped data elements. These changes would allow CCORP to retain its alignment with the updated STS elements, thereby reducing the reporting burden to the hospitals.

**Action: The CAP approved all proposed wording changes, drops and adds to CCORP data elements effective July 1, 2014.**

#### **10. Definition of Isolated CABG**

Dr. Hoegh advised the Panel that OSHPD continually reviews the CCORP definition of isolated CABG. She explained that Dr. Steimle, consultant to OSHPD, has made changes over time based on issues presented to him during data submission and data audits. Dr. Hoegh directed the Panel to review the training handbook and handout that identify those things that make a CABG isolated or non-isolated.

Dr. Shemin brought up MAZE and the clinical implications between performing the surgery by opening the heart or not opening the heart. It had been previously agreed upon by the Panel that all MAZEs are would be included no matter how minor. This is a deviation from STS which excludes all MAZES.

The Panel discussed the different MAZE procedures and acknowledged that the risk of stroke and other outcomes changes based on the type of MAZE performed. Further discussion about MAZE as an outcome measure and whether it should be excluded will be discussed at the next Panel meeting.

The Panel went on to discuss a new device, the Impella, and whether it should be included in the definition of isolated CABG if the intent is to measure outcomes. Dr. Steimle proposed to list Impella as an inclusion in the definition of isolated CABG.

**Action: The Panel approved the revised definition of Isolated CABG to include Impellas**

**11. Preliminary methods and risk-adjusted mortality model of CABG + Valve Outcomes – Zhongmin Li, Ph.D., University of California, Davis, OSHPD contractor**

Dr. Li presented basic statistics to show the volume and mortality trends for valvular surgeries performed between 1997 through 2012. He also incorporated previous Panel recommendations into the model. Those were: use of multiple years of data, selection of a homogenous cohort for risk adjustment and public reporting, and exclusion of cases with pulmonic or tricuspid valve op.

Handouts included a variety of tables based on 2010-2011 data and included the mortality model. Dr. Li indicated that the risk-adjusted Valve + CABG models performed well and that STS-Like and NY-Like models produced similar results. Publicly reporting on Valve + CABG outcomes will support the full implementation of State legislation. Further research needs to be done to determine the viability of reporting at the surgeon level.

There was also discussion about whether or not OSHPD should provide the hospitals with advance written notification that they will be reporting on risk-adjusted mortality outcomes for Valve + CABG. It was agreed that the hospitals are aware that this information is collected and that it could be included in the 2011-2012 public report.

**Action: The Panel approved the CCORP-adapted STS risk-adjusted mortality model for Valve + CABG Outcomes to be used for the 2011-2012 data.**

**12. Discussion of agenda topics for next meeting**

Dr. Brindis led a “Blue Sky” discussion and the Panel brainstormed about other potential topics and/or reporting measures. There was consensus that providing reports relative to cost transparency data, e.g., comparing hospital charges/costs for CABG, is important in the current healthcare climate and necessary to consumers. It was pointed out by Dr. Parker that this may not be consistent with statute and data could be difficult to obtain, but it would certainly be researched by CCORP staff.

Further topics for the next Panel meeting:

- Audit results
- Risk models
- Per Capita Data

- DNR as a potential outcomes measure

### **13. Public Comment**

Dr. Carey commented that he did not agree with reporting on only one type of valve surgery, (CABG + Valve), and not another. He stated that none of the other reporting agencies report on just one.

Dr. Brindis reiterated current State law and how reporting on CABG + Valve will satisfy the rules of the law.

### **Adjourn**

Dr. Brindis adjourned the meeting at 3:09 p.m.